HEALTH QUESTIONNAIRE

Name		Birth Date mo day year
Physician's Name	Phone ( )	Date Last Visit
Address	City	State/Zip
Dentist's Name	Phone ( )	Date Last Visit
Address	City	State/Zip

Major dental problem or reason _____

	Yes	No
Have you had an unexplained gain or loss of weight (past 6 months)? How much?_____	☐	☐
Do you smoke or use tobacco? If Yes, how much?_____	☐	☐
Do you drink alcoholic beverages? If Yes, how much?_____	☐	☐
Have you ever been treated for cancer?	☐	☐
Have you ever had radiation treatment?	☐	☐
Do you have a poor appetite?	☐	☐
Do you sleep poorly or use medications to sleep?	☐	☐
Do you feel that you are currently more tired than usual?	☐	☐
Do you have many body aches and pains?	☐	☐
Do you have night sweats or recurring fever?	☐	☐
Have you ever used intravenous drugs?	☐	☐
Have you used cocaine or "crack" within the past 6 months?	☐	☐
Do you actively engage in high risk behavior for infectious diseases (e.g., AIDS, hepatitis)?	☐	☐

Please describe your general health _____

Do you have or have you ever had:

HEAD AND NECK	Yes	No
Recurrent headaches	☐	☐
Glaucoma / eye disease	☐	☐
Recurrent earaches / hearing problems	☐	☐
Chronic sinusitis / post-nasal discharge	☐	☐
Recent difficulty swallowing	☐	☐
Persistent sore throat and hoarseness	☐	☐
Swollen neck glands	☐	☐
Recurrent neckache or neck pain	☐	☐
Injury to head, neck, jaw, teeth	☐	☐

DENTAL	Yes	No
Chronic face pain	☐	☐
Clicking / popping jaw	☐	☐
Difficulty opening or closing jaw	☐	☐
Unable to chew food well	☐	☐
Blisters / sores on lips or mouth	☐	☐
Unpleasant taste / bad breath	☐	☐
Burning tongue / lips	☐	☐
Swelling / lumps in mouth	☐	☐
Bleeding or infected gums	☐	☐
Loose teeth	☐	☐
Pain when chewing or opening mouth	☐	☐
Bothersome catching of food between teeth	☐	☐
Recent toothache / sensitivity	☐	☐
Uncomfortable bite	☐	☐
Recent need to chew on one side	☐	☐
Clenching / grinding	☐	☐
Your bite adjusted	☐	☐
Bite appliance (TMJ splint)	☐	☐
Gum treatment or surgery	☐	☐
Orthodontic treatment (braces)	☐	☐

Do you have or have you ever had:

NEUROMUSCULAR SYSTEM	Yes	No
Fainting spells or loss of consciousness	☐	☐
Seizures	☐	☐
Numbness, tingling, or paralysis	☐	☐
Recurrent backaches	☐	☐
Problem / walking, balance, dizziness	☐	☐
Persistent stiffness or painful joints	☐	☐
Artificial bone or joint implants	☐	☐
Recent or unusual headaches	☐	☐

RESPIRATORY	Yes	No
Breathing problems	☐	☐
Asthma or emphysema	☐	☐
Tuberculosis or a persistent cough	☐	☐
Coughed up blood	☐	☐
Pneumonia	☐	☐

CARDIOVASCULAR	Yes	No
High blood pressure	☐	☐
Difficulty breathing upon awakening	☐	☐
Difficulty breathing when lying down	☐	☐
Swollen ankles	☐	☐
Irregular or rapid heart beats	☐	☐
Chest pain due to physical exertion	☐	☐
Chest pain when upset	☐	☐
Rheumatic heart disease or fever	☐	☐
Congenital heart disease / heart murmur	☐	☐
Prolapsed heart valve	☐	☐
Cardiac or vascular surgery	☐	☐
Heart attack and/or angina	☐	☐
Other heart problem	☐	☐
A stroke	☐	☐

HEALTH QUESTIONNAIRE

Do you have or have you ever had:

GASTROINTESTINAL / GENITO-URINARY	Yes	No
Persistent diarrhea / odd colored stools	☐	☐
Colitis or ulcers	☐	☐
Unexplained vomiting / frequent nausea	☐	☐
Alcoholic liver disease	☐	☐
Hepatitis or other liver disease	☐	☐
Jaundice (yellow skin or eyes)	☐	☐
Awaken more than twice a night to urinate	☐	☐
Kidney disease / renal dialysis	☐	☐
A kidney transplant	☐	☐
Any urinary infection	☐	☐
Syphilis	☐	☐
Gonorrhea	☐	☐
Any other sexually transmitted disease	☐	☐

Do you have or have you ever had:

HEMA / ENDO / IMMUNE	Yes	No
Bruise easily / bleed excessively after a cut	☐	☐
A blood transfusion	☐	☐
Anemia or denied permission to give blood	☐	☐
Leukemia (cancer of the blood)	☐	☐
Diabetes or been frequently thirsty	☐	☐
Thyroid or adrenal gland disease	☐	☐
AIDS or ARC (AIDS Related Complex)	☐	☐
Positive blood test for HIV antibodies	☐	☐
Skin blotches or rash	☐	☐
Rheumatoid arthritis	☐	☐
Chronic itching	☐	☐

Have you been allergic to or had a bad reaction to:

ALLERGIES	Yes	No
Penicillin	☐	☐
Sulfa drugs	☐	☐
Dental anesthetics	☐	☐
Metals (rings / earrings)	☐	☐
Other (specify) _____	☐	☐

WOMEN ONLY

	Yes	No
Do you menstruate regularly?	☐	☐
Do you flow heavily?	☐	☐
Are you taking birth control pills?	☐	☐
Are you now pregnant?	☐	☐
If so, please give due date _____		
Are you in or have you passed through menopause (change of life)?	☐	☐
Are you taking hormones?	☐	☐

Has anyone in your family (grandparent, parent, sibling, child) ever had:

FAMILY HISTORY	Yes	No
Bleeding disorder	☐	☐
Heart disease	☐	☐
Mental / emotional disorders	☐	☐
Cancer	☐	☐
Tuberculosis	☐	☐
Diabetes	☐	☐

Any genetic diseases / illnesses (please specify) _____

BEHAVIORAL	Yes	No
Are you available and able to sit for a three-hour dental appointment?	☐	☐
Are there some aspects of the appearance of your teeth and jaw that need to be changed?	☐	☐
Do you often feel depressed or moody?	☐	☐
Do you often feel anxious or nervous?	☐	☐
Have you ever had psychiatric or psychological counseling?	☐	☐
Did you ever avoid a dental appointment because you were frightened?	☐	☐
Do you ever feel uncomfortable asking questions of doctors?	☐	☐

List all prescription and non-prescription drugs (including aspirin) taken within the past 6 months:

Name	Dosage	Name	Dosage	Name	Dosage
1.		3.		5.	
2.		4.		6.	

Please list all hospitalizations and emergency room visits (include dates and reasons):

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Have you been dissatisfied with previous dental treatment? ____ Yes ____ No If Yes, please describe:

_____

I have read and understood the above questionnaire and have answered all questions truthfully to the best of my ability. If ever my health or medications change, I will inform my dentist at my next appointment.

Patient Signature: X _____ Date: _____ (mo day year) Guardian: _____ Date: _____ (mo day year)